DEPARTMENT OF DEFENSE

The Uniformed Services Federal Employees Health Benefits Program Demonstration Project

UNDERSTANDING YOUR HEALTH CARE COVERAGE

Introduction

The Department of Defense (DoD) is committed to ensuring that Uniformed Services retirees and their family members receive the best possible health care. As such, we want to inform you about a health care demonstration project that extends to you the federal government's highly regarded health benefits program presently enjoyed by federal civilian employees and retirees. The federal Office of Personnel Management (OPM) and DoD sponsor this three-year demonstration project jointly.

In selected areas of the United States and Puerto Rico, the Federal Employees Health Benefits Program (FEHBP) Demonstration Project is being offered to many Medicare-eligible Uniformed Services retirees and their family members. An important feature includes coverage that can be extended to family members who are not Medicare eligible. The project is also open to certain other individuals who are not eligible for Medicare, such as surviving dependents and certain unremarried former spouses.

The bottom line is that you and your family may be able to obtain premium health insurance coverage at a reduced cost. This demonstration project extends the same health care benefits as the federal government's health benefits program for its career civilian employees.

This handbook has been prepared to provide information about the demonstration project and to explain how your other health insurance programs may be affected by participating in the demonstration project. After reviewing the handbook, you will find an enrollment application enclosed if you wish to enroll in the FEHBP demonstration project.

If you have additional questions, you may call the DoD Customer Care Center toll free, Monday through Friday, from 8 a.m. to 6 p.m. Eastern Time: 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778. Also, if you have access to the Internet, please consult the DoD Web site at www.tricare.osd.mil/fehbp *or–for more general information–the OPM Web site at* www.opm.gov.

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Overview

What is the Federal Employees Health Benefits Program (FEHBP)?

The Federal Employees Health Benefits Program provides comprehensive health benefits through contracts with about 300 health benefits (insurance) carriers. It is the largest employer-sponsored health benefit program in the country. FEHBP plan carriers provide health coverage for over 9 million active and retired civilian employees of the U.S. government and the U.S. Postal Service, and their families. Some of the most reputable private insurers are included in the list of FEHBP health plan carriers.

How does FEHBP work?

Through its contracted health programs, FEHBP offers health benefits through numerous health plans. Participants choose the plan that best fits their health needs and budget. Once a beneficiary selects a plan from the options provided, the federal government pays a percentage of the health care premium and the enrollee pays the remainder.

What is the FEHBP Demonstration Project?

The FEHBP Demonstration Project is a three-year trial in which eligible former Uniformed Services members and other eligible beneficiaries may receive their health benefits through one of the health plans sponsored by the FEHB Program. The Department of Defense and the Office of Personnel Management are jointly sponsoring the congressionally mandated demonstration project.

The FEHBP Demonstration Project will be referred to as the demonstration project throughout the rest of this handbook.

How long will the demonstration project last?

The demonstration project started January 1, 2000, and is currently scheduled to end December 31, 2002. Depending on the success of the program, Congress may decide to extend the demonstration project beyond its current December 31, 2002, end date.

What are the advantages of enrolling in this demonstration project?

You may find the following program features attractive:

- You receive extensive health benefits at a low cost.
- From a variety of health plans, you may choose the one that best meets your and your family's health care needs.
- You may receive health coverage for services that Medicare does not cover, such as dental and vision care, prescription medications, routine physicals, and emergency care outside the United States.

- You may join regardless of your current health status.
- You have no annual or lifetime cap on prescription drug coverage.
- You have the opportunity to change your health care plan yearly during Open Season, which runs from November 13 through December 11, 2000, for health care coverage beginning January 1, 2001. November 12 through December 10, 2001, is the Open Season for coverage beginning January 1, 2002.
- Your out-of-pocket costs will most likely be lower than the costs under your current plan.

What are the differences between the civilian FEHBP and this demonstration project?

The health care benefits are the same. There are a few slight differences in other areas:

- This demonstration project is available only in certain geographical areas.
- The eligibility requirements are different.
- The premiums may vary.

How were the demonstration sites selected?

Ten counties were randomly selected from across the country to be the center of each of the 10 demonstration sites. The sites were then enlarged by systematically adding ZIP codes around the selected counties until they reached a predetermined number of eligible people.

Where are the demonstration sites?

There are 10 demonstration sites, which are defined by U.S. Postal Service ZIP codes. The following is a list of the sites:

- Dover, Delaware area, including parts of Maryland
- Commonwealth of Puerto Rico
- Ft. Knox, Kentucky area, including parts of Indiana
- Greensboro/Winston-Salem/High Point, North Carolina area
- Dallas/Ft. Worth, Texas area
- Humboldt County, California area, including extensive parts of Northern California
- Camp Pendleton, California area, including extensive parts of Southern California
- New Orleans, Louisiana area
- Adair County, Iowa area, including most of Iowa and parts of Kansas, Minnesota, Missouri, Nebraska and South Dakota
- Coffee County, Georgia area, including extensive parts of Georgia and parts of Florida and South Carolina.

For a complete list of ZIP codes included in the demonstration sites, please visit the Military Health System Web site at *www.tricare.osd.mil/fehbp*.

Eligibility

Who is eligible to enroll in this demonstration project?

To enroll in this demonstration project, you must reside within one of the 10 demonstration sites *and* must fit *one* of the following descriptions:

- A Uniformed Services retiree who is eligible for Medicare Part A. The term "retiree" includes both retirees age 65 and over, and those who are medically retired, are Military Health System (MHS) eligible and continue to be valid holders of a Uniformed Services ID card.
- An individual who is eligible for Medicare Part A and is also a dependent of a Uniformed Services retiree. Note that the retiree does not need to be eligible for Medicare Part A for the dependent to be eligible to enroll in this demonstration project.
- A Uniformed Services retiree's unremarried former spouse who meets certain additional eligibility requirements. An unremarried former spouse does not have to be Medicare eligible to participate in the demonstration project.
- A survivor of a former Uniformed Services member. A survivor is a dependent entitled to Military Health System benefits due to a Uniformed Services member's death either while on active duty or after retirement. A survivor does not have to be Medicare eligible to participate in the demonstration project.

Family members may be extended FEHBP coverage by the eligible enrollee.

What are the Uniformed Services?

The term Uniformed Services is used to include the following groups:

- Members of the Armed Services (Army, Navy, Air Force, Marine Corps and the Coast Guard)
- Members of the Commissioned Corps of the Public Health Service
- Members of the Commissioned Corps of the National Oceanic and Atmospheric Administration

Please note that the term Uniformed Services will be used throughout this handbook to include all of these groups.

How can I find out if I am eligible for the demonstration project?

You may call the DoD Customer Care Center, which will check the Defense Enrollment Eligibility Reporting System (DEERS) to determine your eligibility.

It is the sponsor's responsibility to make sure that family members are entered in DEERS. This can be accomplished through the nearest military personnel office, or by contacting the DEERS Telephone Center.

Uniformed Services sponsors should ensure that all personal and family information is current in the DEERS files.

How do I update my DEERS information?

You can contact the DEERS Telephone Center, Monday through Friday from 9 a.m. to 6:30 p.m. Eastern Time:

- 1-800-538-9552
- 1-800-334-4162 (California only)

Do I have to be enrolled in Medicare Part B to be eligible for the demonstration project?

No. You do not need to be enrolled in Medicare Part B to be eligible for this demonstration project. However, if you already have Medicare Part B, we recommend you keep it. Under Medicare, there is a significant penalty for purchasing Medicare Part B after the initial eligibility period. Also, Medicare Part B works in conjunction with FEHBP to hold down your out-of-pocket costs. That is, if you have Medicare Part B, your FEHBP policy will cover most, if not all, of your Medicare coinsurance and deductible fees.

If I am eligible to enroll, but my spouse isn't, does that mean he/she can't be covered?

No. You can extend coverage to all of your dependents through a self-and-family policy. The earlier description of who is eligible refers only to those individuals who can enroll on their own.

Do the qualifying dependents have to be eligible for or enrolled in Medicare to be covered under a self-and-family policy in this demonstration project?

No. Dependents of Uniformed Services retirees do not need to be eligible for or enrolled in Medicare to be covered in this demonstration project.

How are dependents defined?

Dependents are defined as a Uniformed Services retiree's spouse and unmarried dependent children under age 22, including legally adopted children and children born out of wedlock.

Stepchildren and foster children (including grandchildren, if they qualify as foster children) are included if they live with the Uniformed Services retiree in a regular parent-child relationship.

Also, an unmarried dependent child age 22 or over who is incapable of self-support because of a mental or physical incapacity that existed before age 22 may qualify for coverage under certain conditions.

If I move to a *temporary* residence during the year, am I still eligible to participate in this demonstration project?

As long as you retain a permanent residence in one of the 10 demonstration sites, you remain eligible to participate in this demonstration project.

If I move *permanently*, am I still eligible to participate in this demonstration project?

If your new residence is in one of the 10 demonstration sites, you are still eligible to participate in this demonstration project. You should check with your health plan to be sure it offers coverage in your new area, even if it is in the same demonstration site. Unfortunately, you are not eligible to continue participating if your new residence is *not* in a demonstration site.

Regardless of where you move, please notify the DoD Customer Care Center toll free, Monday through Friday from 8 a.m. to 6 p.m. Eastern Time, 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778. Remember also to call the DEERS Telephone Center at 1-800-538-9552. (In California, call 1-800-334-4162.)

What happens to my health coverage if I become ineligible for the demonstration project?

Individuals who cease to be eligible as a family member under your self-and-family coverage may apply for a program called temporary continuation of coverage (TCC). Such individuals include a child who turns 22 or marries, as well as a Uniformed Services retiree's divorcee who does not qualify to enroll as an unremarried former spouse under Title 10 of the U.S. Code.

What is temporary continuation of coverage (TCC)?

TCC is a program in which your FEHBP health benefits remain in effect when you are no longer eligible for the demonstration project. The government does not pay any portion of the premium. There are also program limits to TCC, and eligibility will not extend beyond the end of the demonstration project. Call the DoD Customer Care Center for more information toll free, Monday through Friday from 8 a.m. to 6 p.m. Eastern Time, 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778.

Health Coverage

For those eligible to participate in the FEHBP Demonstration Project, this section provides information about the health benefits and types of health plans available for participants. You will also find information about how participation affects other Department of Defense health benefits.

What types of coverage are available?

You can choose between two types of coverage:

- Self-only coverage, which covers only the eligible person who enrolls, or
- Self-and-family coverage, which also covers most family members/dependents of the eligible person.

What family members are included in self-and-family coverage?

Self-and-family coverage includes coverage for you, your spouse and unmarried dependent children under the age of 22, including legally adopted children and children born out of wedlock. Under certain circumstances, your enrollment may cover your disabled child 22 years or older who is incapable of self-support.

What types of health plans are available under this demonstration project?

There are two types of plans available:

- Fee for service (FFS)
- Health maintenance organizations (HMOs)

Medical Services Covered

What are the principal benefits of the plans in this demonstration project?

The benefits vary depending on the health plan you choose.

The following list includes a sampling of benefits that may be available, depending on the plan:

- Inpatient hospitalization
- Inpatient surgical services
- Outpatient care, such as physician's office visits, routine physicals, outpatient surgery, outpatient physical therapy, speech therapy, occupational therapy, and diagnostic procedures
- Preventive services
- Rehabilitation services
- Emergency care (including care received outside of the United States)
- Mental health services
- Substance abuse services
- Prescription medications
- Dental care
- Vision care

Will prescription medications be covered?

Yes. The amount of coverage depends on the health plan you choose. While each plan offers prescription coverage, the specific coverage and out-of-pocket costs vary. Some non-FEHBP health plans have annual benefit limits on prescription drugs. FEHBP health plans do not.

Where can I purchase prescription medications?

Check with your health plan to obtain a list of participating pharmacies in your area. Most FEHBP health plans allow prescription medications to be purchased through retail and/or mail order pharmacies.

If I enroll in this demonstration project, will I be able to use my Base Realignment and Closure (BRAC) pharmacy benefit?

No. If you are eligible for the BRAC pharmacy benefit, your eligibility will be suspended while you are enrolled in the demonstration project. However, your BRAC benefit will be restored immediately if you withdraw from the demonstration project, or if the demonstration project ends.

What is the BRAC benefit?

Base closures affected the pharmacy benefit of Medicare-eligible beneficiaries and their family members who lived near the former bases. Under the Base Realignment and Closure (BRAC) pharmacy benefit, these eligible beneficiaries may purchase medications from TRICARE network retail pharmacies or the National Mail Order Pharmacy (NMOP).

If I enroll in this demonstration project, may I continue to receive my medications from the military treatment facility pharmacy?

No. While you are enrolled in the demonstration project, you are *not* eligible to receive health care at a military hospital or clinic, including use of their pharmacies. Your benefits will be restored immediately if you withdraw from the demonstration project or if the demonstration project ends.

If I am eligible for pharmacy coverage through TRICARE and I enroll in this demonstration project, can I also use the TRICARE network for pharmacy coverage?

No. You may *not* use the TRICARE network for pharmacy benefits while you are enrolled in this demonstration project. However, your benefits will be restored immediately if you withdraw from the demonstration project or if the demonstration project ends.

If I currently receive my medications from a Department of Veterans Affairs (VA) pharmacy, can I continue to do so if I enroll in the demonstration project?

Yes. If you currently receive your medications from a VA pharmacy, enrolling in the demonstration will *not* affect your eligibility to use a VA pharmacy's services.

Accessing Health Care

Where can I get care if I am enrolled in this demonstration project?

That depends on the plan you choose, so it is important that you read the materials provided about your

plan. Fee-for-service (FFS) plans cover costs incurred for care by health care providers across the United States and in most countries around the world. Health maintenance organizations (HMOs), on the other hand, cover care provided primarily by a network of doctors and hospitals in a particular geographic or service area.

How do I find providers who participate in the plan I choose?

The plan you choose publishes a directory of participating providers. Contact your insurance carrier for this information.

Can I continue to receive care at the military treatment facility or clinic?

No. Demonstration project enrollees are *not* eligible for any type of care or services from a military hospital or clinic, except in an emergency.

Where do I receive care when traveling outside the program area?

Since plans vary, please refer to your health plan for more information.

Can I continue to receive care at a Department of Veterans Affairs (VA) facility?

Yes. Enrolling in the demonstration project does *not* affect your ability to use VA services.

Costs

Premiums

Is there a premium to participate in this demonstration project?

Yes. You are responsible for paying your share of the premium for the health plan you select. The amount depends on the plan you choose. The government typically pays up to 75 percent of the premium for you.

How much are the premiums?

The premium amount depends both on the health plan you choose and on whether you choose self-only coverage, or self-and-family coverage.

Each plan's premium rates are listed in the *Guide to the Federal Employees Health Benefits Plans Participating in the Department of Defense FEHBP Demonstration Project*. Published each fall by the Office of Personnel Management, this guide contains a complete listing of available health plans and their premiums. The guide can be ordered by calling the DoD Customer Care Center toll free, Monday through Friday from 8 a.m. to 6 p.m. Eastern Time, 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778.

Does the government pay any part of the premium?

The government contributes a substantial amount toward the total cost of your premium. In 2000, the government paid up to $2,049.60 for each self-only policy and $4,575.24 for each self-and-family policy. The government contributes up to 75 percent of the total premium for all plans available under the demonstration project.

How does a health plan determine premiums?

Health plan premiums are based on several factors including the type of benefits that are offered, the cost of claims paid by the plan, and health plan administrative costs.

Do the health plan premiums remain the same every year?

Not necessarily. Each year, benefits and rates are negotiated by the Office of Personnel Management for all health plans participating in FEHBP.

If my spouse and I are each independently eligible to enroll in this demonstration project, can we purchase two self-only policies instead of a self-and-family policy?

Yes. You may purchase two self-only policies. Here are some things you should consider:

- Is my health outlook such that I expect to approach the catastrophic cap for out-of-pocket costs?
- Will I save on premiums?

Will what I save on premiums be offset by a higher catastrophic cap?

Depending on the plan selected, the catastrophic cap of two self-only policies may have a higher out-of-pocket cost than one self-and-family policy. In this situation, it could cost significantly less if a self-and-family policy is purchased.

Premium Payment Options

What are my premium payment options?

You may pay your premium through one of four options:

- *Direct bill*—You will receive a periodic billing statement for the premium owed.
- *Allotment deduction*—You will have your premium automatically deducted by allotment from your retired pay.
- *Electronic funds transfer*—You will have your premium automatically transferred from your checking or savings account.
- *Credit card*—You will have your premium charged directly to a major credit card.

What is the direct bill payment option?

Under this payment option, you will receive a billing statement indicating the amount owed. You are responsible for mailing your payment and remittance slip by the due date. Beneficiaries should be cautious about using this payment option because any delay or lapse in payment will result in permanent cancellation of your health coverage in the demonstration project.

What guidelines do you have for paying the premium by allotment from my retirement check?

The specific guidelines for using this method of payment are as follows:

- The sponsor who earned the retired pay *must sign* the Payment Election Form (found at the back of this handbook) to request the deduction from his or her retired pay.
- If two self-only coverage options are chosen, these two premiums can be combined into one deduction from the allotment, as long as the sponsor signs the Payment Election Form to request the deduction from his or her retired pay.
- For survivors (dependents of a deceased sponsor), the allotment option is *not* available.

How does the electronic funds transfer (EFT) option work?

You will be provided an EFT statement detailing the premium due and the date the transfer will occur. On this date, the premium due will be transferred from your checking or savings account in payment

of premium. Your bank will post the entry from your checking or savings accounts; the transaction will show up on your account statement.

What information is needed to process my electronic funds transfer?

Select the account, either checking or savings, from which you want to have the funds transferred. The owner of this account must sign a Payment Election Form. If funds are to be transferred from a checking account, a blank check should be submitted with "VOID" written across the front. If funds are to be transferred from a savings account, you will need to provide the savings account number, the ABA number, and your bank's name and address.

How do I obtain my ABA number?

Your ABA number is the first nine digits of the number printed on the bottom of your checks or deposit slips. The ABA number should start with a 0, 1, 2, or 3. Your bank can also provide you with your ABA number.

When will the EFT transfer occur?

You will be provided with an EFT statement detailing the premium due and the date the transfer will occur. The transfer will generally occur on the 15th day of the month. Should the 15th fall on a weekend or holiday, the EFT transfer will occur on the last working day before the 15th. You will be notified by an EFT statement if the transfer will occur on a different day.

How does the credit card payment option work?

Your credit card account will be debited monthly on the dates premium payments are due.

Other Out-of-Pocket Costs

Are there other costs to me?

Besides the premium, you may incur costs such as deductibles, coinsurance, or copays. However, if you are Medicare eligible and have both Medicare Parts A and B, your FEHBP health plan deductibles and copays are usually waived for services also covered by Medicare.

A deductible is the amount you pay out-of-pocket for health care costs before your insurer begins covering all or part of the bills.

A copay is the fixed amount or percentage you pay for each medical service, such as a doctor's visit.

What is a catastrophic cap?

A catastrophic cap is the most you will pay for health care in a year's period of time, not counting the premium. For FEHBP plans, the year corresponds to the calendar year, January 1 through December 31.

Do health plans under the FEHBP Demonstration Project have a catastrophic cap?

Most plans have a catastrophic cap. The catastrophic cap varies from plan to plan. Note that the premium cost does not apply toward the catastrophic cap.

Enrollment

When you make the decision to participate in the FEHBP Demonstration Project, you must notify the Department of Defense of your decision. If you have received health care until now primarily through the Military Health System, you must become familiar with a few important FEHBP procedures. For example, you cannot enroll just any time during the year, except under very special circumstances. We ask you to pay particular attention to the following enrollment instructions.

How do I enroll in this demonstration project?

To enroll in this demonstration project, complete and send in the Health Benefits Election Form and the Payment Election Form found in the back of this handbook.

When can I enroll in this demonstration project?

You may enroll during the annual FEHBP Open Season or within a specified time frame before or after a life event.

What is Open Season?

Open Season is a term used to describe the annual time frame for enrollment in FEHBP. It is also a time when enrollees can change health plans. Eligible beneficiaries may enroll from November 13 through December 11, 2000, for medical coverage beginning January 1, 2001. For medical coverage beginning January 1, 2002, eligible beneficiaries may enroll from November 12 through December 10, 2001.

If I enroll during Open Season, when will my FEHBP coverage become effective?

The effective date of your medical coverage is January 1 of the year following the Open Season. You can use your benefits as soon as your coverage is effective. There are no waiting periods, required medical examinations, or restrictions because of age or physical condition.

If I am eligible for the demonstration project and do not enroll during Open Season, can I enroll at a later date?

Other than during Open Season, you may enroll only if you experience a qualifying life-changing event. A life event is a major event in your or your family's lives that affects your need for health care coverage. Depending upon the life event, you may enroll in a self-only policy or change to a self-and-family policy up to 31 days before and up to 60 days after the life event. Call the DoD Customer Care Center for more information about your specific life event.

What are the life events that would allow me to enroll other than during Open Season?

The following are examples of life events that allow you to enroll in this demonstration at times other than Open Season:

- Change in marital status
- Birth or adoption of a child
- Other family status change
- Move from a health maintenance organization's (HMO's) area
- Termination of membership in an employee organization
- Attaining eligibility for Medicare
- Loss of coverage under a non-federal health plan
- Move into a demonstration site

If I enroll in this demonstration project, which health plan should I choose?

Only you can decide which health plan best fits your needs. An attractive feature of enrolling in this demonstration project is that you can choose from among a wide array of health plans, most of which offer more benefits at a lower cost than commercial or private health insurance plans.

Is there specific health plan information available?

Yes. Information on your area's FEHBP Demonstration Project health plans is updated each fall. You may request plan brochures from the DoD Customer Care Center by calling toll free, Monday through Friday from 8 a.m. to 6 p.m. Eastern Time, 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778.

If I enroll in this demonstration project, can I still get care from a military treatment facility?

No. If you enroll in this demonstration project, you will *not* be eligible to receive care from a military hospital or clinic, except in an emergency.

I am currently enrolled in FEHBP through my past federal government civil service employment. Can I switch to this Department of Defense demonstration project instead?

No. You are not eligible to enroll in the Department of Defense demonstration project if you are enrolled or eligible to enroll in FEHBP through federal civil service employment or retirement.

Can I enroll other members of my family on my Health Benefits Election Form?

Yes. You may extend coverage to other members of your family by selecting a self-and-family policy.

When can enrollment changes be made?

Each year you have the opportunity to enroll or change plans during the Open Season. Open Season is November 13 through December 11, 2000, for health coverage beginning January 1, 2001. For health coverage that begins January 1, 2002, the Open

Season is November 12 through December 10, 2001. During Open Season, you may:

- Enroll if you are eligible and currently not enrolled.
- Change from one plan to another.
- Change your coverage options from self-only to self-and-family. Note that you may change from self-and-family coverage to self-only at any time.

What happens if the demonstration project ends on December 31, 2002?

If the demonstration project ends as currently scheduled on December 31, 2002, your Military Health System coverage will resume on January 1, 2003. Your Medicare coverage also continues. If you had a previous supplemental policy, you will need to check with the carrier regarding resumption of coverage.

Note that, as mentioned earlier, Congress may decide to extend the demonstration project beyond its current December 31, 2002, end date.

Withdrawing from the Program/Disenrollment

For any number of reasons, you may wish to withdraw from the FEHBP Demonstration Project before it ends. Also, the program requires that you adhere to the rules, such as paying on time and residing permanently in the demonstration area. This section discusses the flexibility to withdraw from the demonstration project before the end of the demonstration.

May I cancel my enrollment in this demonstration project?

Yes. You may cancel your demonstration project enrollment (or disenroll) at any time. Disenrollment becomes final at midnight on the last day of the month you request it.

What do I have to do to leave or disenroll from the demonstration project?

To request a disenrollment form, please call the DoD Customer Care Center toll free, Monday through Friday from 8 a.m. to 6 p.m. Eastern Time, 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778.

The disenrollment effective date is midnight of the last day of the month the request is received at the DoD Customer Care Center, unless you have requested to withdraw from the program in a later month. Regardless, the disenrollment effective date is the last day of the month. Please remember that you are responsible for paying your premiums through your last day of coverage.

If I disenroll, when will my Military Health System coverage be reinstated?

Once your disenrollment is processed, your Military Health System coverage will be reinstated effective the day following your disenrollment effective date. There will be no interruption in coverage.

Can I re-enroll in this demonstration project if I disenroll?

No. You may not re-enroll in this demonstration project if you disenroll either voluntarily or involuntarily from this demonstration project.

Can I be involuntarily disenrolled from the demonstration project?

Yes. You can be disenrolled if you do not meet your responsibilities. For example, you can be disenrolled if you do not pay your premiums on time.

Policyholder Responsibilities

In a health care system that protects consumers' rights, you are encouraged to understand your health care plan(s) and to assume certain responsibilities. Your understanding of the Federal Employees Health Benefits Program (FEHBP) Demonstration Project will help ensure that you receive the highest quality and most cost-effective care available.

What are your responsibilities as an enrollee in the DoD FEHBP Demonstration Project?

You can ensure that your FEHBP membership operates smoothly by understanding your responsibilities as an enrollee:

- Be aware of your plan's benefit package.
- Understand your plan's exclusions and limitations.
- Follow the plan's precertification and preauthorization requirements.
- Ensure that your health care provider participates—or will continue to participate—in your plan's networks or preferred provider arrangements by checking the plan provider directories or asking your provider directly.
- Know your premium charges.
- Pay your premiums on time.
- Submit reimbursement claims on time and with the necessary documentation.
- To enroll or change enrollment information, file the appropriate form (SF2809) with the DoD Customer Care Center on a timely basis.
- If a family member ceases to be eligible under your FEHBP Demonstration Project health plan and you want to continue that family member's health coverage, ask the DoD Customer Care Center about temporary continuation of coverage (TCC).
- Notify DEERS, the DoD Customer Care Center and your health plan of any life events such as the following:
  - If a family member ceases to be eligible.
  - Upon the death of a family member or sponsor. Also, provide a copy of the death certificate to DEERS.
  - Following a birth, adoption, marriage, or other such life event.
  - If you change your permanent residence.
- To withdraw from the demonstration project, contact the DoD Customer Care Center by calling toll free, Monday through Friday from 8 a.m. to 6 p.m. Eastern Time, 1-877-DOD-FEHB (1-877-363-3342). To communicate in Spanish, call 1-866-DOD-FEHB (1-866-363-3342). The TTY number for the hearing or speech impaired is 1-877-535-6778.

Summary of the FEHBP Demonstration Project

Topic	Explanation
Eligibility	All individuals enrolling in the program must live within one of the 10 FEHBP Demonstration Project sites *and* must fit *one* of the following descriptions: • A Uniformed Services retiree who is eligible for Medicare Part A. The term "retiree" includes both retirees age 65 and over, and those who are medically retired, are Military Health System (MHS) eligible and continue to be valid holders of a Uniformed Services ID card. • An individual who is eligible for Medicare Part A and is also a dependent of a Uniformed Services retiree. Note that the retiree does not need to be eligible for Medicare Part A for the dependent to be eligible to enroll in this demonstration project. • A Uniformed Services retiree's unremarried former spouse who meets certain additional eligibility requirements. An unremarried former spouse does not have to be Medicare eligible to participate in the demonstration project. • A survivor, which is defined as a dependent entitled to Military Health System benefits due to a Uniformed Services member's death either while on active duty or after retirement. A survivor does not have to be Medicare eligible to participate in the demonstration project.
Choice of coverage	Self-only Self-and-family
Choice of plan types	Fee-for-service (FFS) Health maintenance organization (HMO)
Choice of physician	FFS plans allow you to choose your health care provider(s). Normally with an HMO, only health care services received from the plan's approved providers are covered, and specialist care is covered only when the primary care physician has referred the patient. There are exceptions so check with the HMO for their specific policies.
Cost of premium	You are responsible for approximately 25 percent of the cost of the full premium. The government pays the balance. The premium amount depends on the plan you choose.

Summary of the FEHBP Demonstration Project (cont.)

Topic	Explanation
Payment options	Direct billing Allotment deduction Electronic funds transfer from checking or savings account Credit card
Coverage begins	Coverage begins January 1, 2001, if you enroll during the Open Season, November 13 through December 11, 2000. For those who enroll during the Open Season in Fall 2001, coverage begins January 1, 2002. If you enroll due to a life event, coverage generally begins the first day of the month after the enrollment is received.
Key features	Wide choice of health plans and options Covers some health care services that Medicare does not Annual opportunity to change health plans during Open Season Out-of-pocket costs are usually lower No penalty for pre-existing conditions No waiting periods No medical examinations required Typically 75 percent of the health plan premium is paid by the government Temporary continuation of coverage available if eligibility is lost No requirement for Medicare Part B
Medical coverage offered in all FEHBP plans	Inpatient hospitalization Inpatient surgical services Outpatient care Pharmacy coverage Emergency care Mental health services Rehabilitation services Substance abuse services
Additional coverage offered in some FEHBP plans	Dental care Vision care Preventive services

Do not rely on this chart alone for specific information on FEHBP Demonstration Project health coverage. Each FEHBP health plan has specific definitions, limitations and exclusions. You can find specific information on each plan in the respective plan brochures.

Making Your Decision

Choosing a health care plan can be confusing and difficult. Please consider the following questions as you make your decision about participating in this demonstration project.

Do you currently have any pre-existing medical conditions?

FEHBP health plans require no medical examinations and have no restrictions because of age or physical condition.

Is it important for your coverage to include routine and preventive care?

Most participating health maintenance organizations (HMOs) include routine and preventive care for free. See plan brochures for details.

Do you frequently travel overseas?

FEHBP plans include coverage for overseas travel. See plan brochures for specific information.

Is your current health care coverage affordable?

The demonstration project offers health care coverage that is affordable because the government helps pay for your premiums. The government typically pays 75 percent of the premium for any plan you choose.

Do you take prescription medications on a regular basis?

The demonstration project's plans all have pharmacy benefits. If you select a plan with mail order pharmacy, you most likely will save a significant amount on prescription medications.

Do you currently receive your health care coverage through an employer's group plan?

If you leave an employer's group plan when you enroll in this demonstration project, you might not be able to rejoin that plan later. Check with your employer's group plan before changing your coverage.

Will you be able to resume your current health care coverage without restrictions or penalty if you withdraw from the demonstration project?

We advise you to contact your individual plan or your State Health Insurance Assistance Program (SHIP) office for specific answers to this question before changing health care coverage. SHIP telephone numbers are available by contacting the Medicare Choices Helpline toll free at 1-800-MEDICARE (1-800-633-4227). For the hearing or speech impaired, the TTY number is 1-877-486-2048.

Other Health Insurance Programs

For many people, particularly those age 65 and over, the federal government, as well as private insurers, provide health care programs and insurance coverage for both inpatient and outpatient care. Some retired persons remain eligible to participate in employer-sponsored programs. For most others who have worked throughout their careers and have reached age 65, the federal government provides inpatient health coverage through a program known as Medicare Part A. This program is an entitlement and helps cover the cost of hospitalization. Medicare Part B, and other programs designed to cover health care costs beyond those provided by Medicare programs, are also available and should be considered.

This section provides information about those programs and addresses some of the issues you should consider when making your health care choice.

Medicare

What is Medicare?

Medicare is a federal health insurance program for:

- People who are age 65 or over
- Some disabled people under age 65
- People with End-Stage Renal Disease (people with permanent kidney failure who need dialysis and/or a transplant)

Medicare consists of two parts: A and B.

Medicare Part A

What is Medicare Part A?

Medicare Part A helps pay for care that is provided in hospitals and skilled nursing facilities, as well as for hospice and some home health care.

How do I know if I am eligible for premium-free Part A?

The following illustrates eligibility criteria for premium-free Medicare Part A:

If you are under 65 years of age and meet one of the criteria below:

- You have received Social Security disability benefits for at least 24 months, or
- You have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You have End-Stage Renal Disease (ESRD).

If you are 65 years of age or older and meet one of the criteria below:

- You are receiving or are eligible for retirement benefits from Social Security or the Railroad Retirement Board, or
- You or your spouse had Medicare-covered government employment.

How do I apply for Medicare Part A?

If you meet the eligibility requirements for premium-free Medicare Part A, your Medicare Part A application is completed automatically by the Social Security Administration when you apply for Social Security benefits.

If you do not meet the eligibility requirements for premium-free Medicare Part A, you may be able to purchase Medicare Part A by applying through the Social Security Administration.

Medicare Part B

What is Medicare Part B?

Medicare Part B helps pay for medically necessary outpatient services such as doctor's visits, outpatient medical and surgical services and supplies, diagnostic tests, physical and occupational therapy, some home health care, and durable medical equipment that Medicare Part A does not cover.

How do I know if I am eligible for Medicare Part B?

You are automatically eligible to purchase Medicare Part B if you are eligible for premium-free Medicare Part A. You are also eligible for Medicare Part B if you are age 65 or over, and a U.S. citizen or permanent resident. The Medicare Part B monthly premium in the year 2000 was $45.50. Please note that this amount may change annually.

How do I apply for Medicare Part B?

If you want Medicare Part B protection to start the month you reach age 65, contact your local Social Security office three months *before* your 65th birthday. If you wait until *after* your 65th birthday, you may enroll only during two specified enrollment periods, which are described below.

The General Enrollment Period

If you sign up during the General Enrollment Period—January 1 through March 31 each year—your Medicare Part B coverage is effective July 1.

The Special Enrollment Period

If you did not sign up for Medicare Part B when you were first eligible because you or your spouse were currently working and were covered under a group health plan, you can still sign up for Medicare Part B during the Special Enrollment Period. Under the Special Enrollment Period, you may sign up for Medicare Part B at any time while you are covered under the group plan. Also, if employment or group health coverage ends, you have eight months to sign up for Medicare Part B.

Please note: Unless you meet the requirements to enroll during the Special Enrollment Period, the Medicare Part B premium increases 10 percent for each 12-month period that you are eligible to enroll in Medicare Part B, but do not. This "late enrollment" penalty does not go away, and will affect your Medicare Part B premiums for life.

Medicare Managed Care

What is Medicare managed care?

Medicare managed care, also known as Medicare+Choice, is a health plan in which a specified group of doctors, hospitals or other health care providers provide care to Medicare beneficiaries in exchange for a fixed monthly payment from Medicare.

Each plan has its own network of hospitals, skilled nursing facilities, doctors and other health care professionals. Services typically must be obtained from the facilities and providers who are a part of that plan. Although many plans do not charge a monthly premium, some may require a minimal monthly payment. For each service rendered, plans typically also charge a small copayment.

What should I do if I can choose between a low-cost Medicare managed care plan and an FEHBP HMO plan?

In some cases, a Medicare managed care plan can offer benefits similar to an FEHBP plan with a lower premium. However, you should review the benefits of both plans closely, especially the prescription drug benefits. Some Medicare managed care plans impose annual benefit limits on prescription drugs that could significantly increase your out-of-pocket costs. FEHBP plans do not impose annual benefit limits on prescription drugs.

Medicare and FEHBP

Do Medicare and FEHBP cover the same types of medical expenses?

Yes. In most cases, your FEHBP plan will pay the Medicare deductible and coinsurance, thereby eliminating most, if not all, of your out-of-pocket costs.

In addition, FEHBP health plans provide extensive coverage for prescription drugs, routine physicals, emergency care outside of the United States, and some preventive services that Medicare does not cover. Some FEHBP health plans also provide coverage for dental and vision care.

Medicare covers some medical expenses that FEHBP plans may not, such as orthopedic equipment, home health care, limited chiropractic services and medical supplies. Check your plan brochure for specifics.

Which insurer will pay my health care costs first—my FEHBP plan or Medicare?

Medicare law and regulations determine whether Medicare or FEHBP is the insurer responsible for paying the initial portion of the total health care cost. The insurer responsible for paying first is called the primary payer. Under most circumstances, Medicare is the primary payer.

If I have Medicare, when will my FEHBP plan pay my health costs first?

Your FEHBP plan is the primary payer when you are an actively working employee, or if you are enrolled only in Medicare Part B (and not in Part A). In addition, your FEHBP plan is the primary payer for you or a covered family member during the first 30 months of eligibility or entitlement to Medicare Part A benefits because of End-Stage Renal Disease (ESRD), regardless of your employment status. Your FEHBP plan brochure provides specific information on how it coordinates benefits with Medicare.

Medigap/Supplemental Insurance

While Medicare and other health care plans provide broad coverage, there may still be out-of-pocket costs associated with the care you receive. Depending on the plan you choose, those costs could be considerable. Special insurance is available to provide additional coverage over and above your standard insurance plan. This section discusses some of those supplemental plans.

What is Medigap?

Medigap is a type of supplemental insurance sold by private insurance companies to fill in the gaps not covered by Traditional Medicare. Although Traditional Medicare covers many health care costs, it does not cover the total cost of medical care for Medicare beneficiaries. Beneficiaries are responsible for coinsurance amounts and deductibles. Plus, there are some medical services that are not covered under Traditional Medicare. For example, custodial nursing home care, most dental care, eyeglasses and most outpatient prescription drugs are not covered.

How many Medigap policies are there?

In most states, federal law requires that any Medigap policy must be sold as one of 10 standardized policies. The policies range from plans offering basic benefits to plans offering the most comprehensive set of benefits. Note that some states may not offer all 10 Medigap policies.

Are all Medigap policies available in all states?

No. Each state determines which of the standardized Medigap policies will be available in its state.

Please note that insurers in Massachusetts, Minnesota and Wisconsin are permitted to sell a somewhat different combination of benefits, although they are likely to be similar to the standardized plans. If you live in one of these states you should contact your local State Health Insurance Assistance Program (SHIP) office or your state department of insurance for more information.

What if I have a "pre-standardized" Medigap policy?

Medigap policies that were sold before mid-1992 were not required to be standardized. If you drop your "pre-standardized" Medigap policy, you will be unable to get it back. Federal law now requires that only standardized Medigap policies be sold.

Why are there so many different Medigap policies?

Each of the 10 Medigap policies offers a different combination of benefits.

What is Medicare SELECT?

Medicare SELECT is a type of standardized Medigap insurance policy. Under Medicare SELECT, beneficiaries choose one of the 10 standardized Medigap plans.

With a Medicare SELECT policy, you may be required to use specific hospitals and doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally charge lower premiums.

Please note that Medicare SELECT may not be offered in your state. For more information on Medicare SELECT, please call your State Health Insurance Assistance Program.

What are the differences among the Medigap policies that different insurance companies sell?

Under federal law, each of the 10 Medigap policies must be the same throughout each state. However, states may allow insurers to offer innovative benefits to any of the 10 standard plans, such as discount arrangements for eyeglasses or prescription drugs from a mail order pharmacy.

Insurance companies compete on price, service and reputation. Different insurance companies also may have different payment schedules. For example, some may collect all the premiums annually while others offer a variety of payment options. All of these factors may affect the premium price.

How much does a Medigap policy cost?

The costs of Medigap policies depend on the policy you buy, where you live and from which insurance company you buy your policy.

Do I need to purchase or maintain a Medigap policy to enroll in this demonstration project?

No. You do not need to purchase or maintain a Medigap policy to enroll in this demonstration project.

May I keep my Medigap policy if I enroll in this demonstration project?

Yes. However, you will have a duplication of coverage if you maintain a Medigap policy while you are enrolled in the demonstration project.

If I drop my Medigap policy when I enroll in the FEHBP Demonstration Project, may I get it back later?

You have certain Medigap protections if:

- You have never been enrolled in a Medicare managed care plan before and
- You leave the FEHBP health plan within 36 months of enrolling.

If you meet the above requirements, you have the right to purchase your former Medigap policy. But you must apply no later than 63 calendar days after your FEHBP health plan coverage ends.

If your former Medigap policy is no longer available, you have the right to purchase Medigap plan A, B, C, or F, if offered in your state. Again, you must apply no later than 63 calendar days after your FEHBP health plan coverage ends.

What do you mean when you say I have protection?

By protection we mean that the insurance company cannot deny you insurance coverage or place conditions on the policy, like making you wait for coverage to start. The insurance company must cover you for all pre-existing conditions. The insurance company cannot charge you more for a policy because of past or present health problems.

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health.

What Medigap protections do I have if I just became Medicare eligible and enroll in this demonstration project?

You may have the right to purchase *any* Medigap policy sold in your state if you withdraw from the demonstration project, provided:

- You joined the demonstration project when you first became eligible for Medicare at age 65,
- You disenroll (withdraw) within 36 months of the effective date of when you first enrolled in the FEHBP Demonstration Project and
- You apply for the Medigap policy no later than 63 calendar days after your FEHBP health plan coverage ends.

What Medigap protections do I have if I had a "pre-standardized" Medigap policy?

If you drop your pre-standardized Medigap policy, you *cannot* get this policy back. However, you have certain Medigap protections if:

- You have never been enrolled in a Medicare managed care plan before *and*
- You leave your FEHBP health plan within 36 months after enrolling.

If you meet the above requirements, you have the right to purchase Medigap plan A, B, C, or F, if offered in your state.

What are my Medigap protections when the demonstration ends?

You have the right to purchase Medigap policy A, B, C, or F if offered in your state, regardless of how many times you have been in a Medicare managed care plan.

Please note that you must apply for the Medigap policy no later than 63 calendar days after your FEHBP health plan coverage ends.

How does FEHBP compare to a Medigap policy?

FEHBP is not a Medigap program. All FEHBP plans include pharmacy coverage and other services that are only available in the most expensive Medigap policies. In most cases FEHBP will cost you less because the government is paying the majority of the premium.

Will my FEHBP fee-for-service plan cover all my out-of-pocket costs not covered by Medicare?

Most FEHBP fee-for-service plans will pay for Medicare deductibles and coinsurance, very much like a Medigap policy. In addition, FEHBP plans will also cover services not covered by Medicare, such as prescription drugs, routine physicals, and preventive services.

What pharmacy coverage is available through a Medigap policy?

If offered in your state, only three Medigap plans offer pharmacy coverage. Medigap plans H and I provide coverage for 50 percent of the cost of prescription drugs up to a maximum of $1,250 per year after you meet a $250 pharmacy deductible per year. Medigap plan J provides coverage for 50 percent of the costs of prescription drugs up to a maximum of $3,000 per year after you meet a $250 pharmacy deductible per year.

How does FEHBP pharmacy coverage compare to Medigap pharmacy coverage?

In almost all cases, FEHBP coverage is superior. Copayments or coinsurance vary depending on the FEHBP plan. FEHBP plans do not have an annual limit as to how much they will pay. In fact, most FEHBP plans have a catastrophic cap that limits how much *you* will pay out of pocket each year.

Where can I find more information on Medigap policies?

You may obtain more information on Medigap policies from the following sources:

- On the Internet, see *www.medicare.gov* or *www.hcfa.gov*.
- Call your State Health Insurance Assistance Program (SHIP). [Note: The SHIP is also known as the State Health Insurance Program (SHIP) or the Senior Health Insurance Information Program (SHIIP) depending on your location.] SHIP telephone numbers are available by contacting the Medicare Choices Helpline at 1-800-MEDICARE (1-800-633-4227). The hearing or speech impaired can call the Medicare Choices Helpline TTY number at 1-877-486-2048.
- The following free publications are available through the Medicare Choices Helpline:

  Medicare Supplemental Insurance Medigap Policies and Protections

  2000 Guide to Health Insurance for People with Medicare

For More Information

For information on the Department of Defense Federal Employees Health Benefits Program (FEHBP) Demonstration Project:

Department of Defense (DoD) Customer Care Center

Department of Defense
TRICARE Management Activity
c/o Iowa Foundation for Medical Care
P.O. Box 71547
Clive, IA 50325-0547

English: 1-877-DOD-FEHB (1-877-363-3342)
Spanish: 1-866-DOD-FEHB (1-866-363-3342)
TDD/TTY: 1-877-535-6778
Monday through Friday, from 8 a.m. to 6 p.m. Eastern Time

Web site: *www.dodcare.com*

The FEHBP Demonstration Project Web site: *www.tricare.osd.mil/fehbp*

Office of Personnel Management (OPM) Web site: *www.opm.gov/insure*

To update your family status and contact information:

Defense Enrollment Eligibility Reporting System (DEERS)

DEERS Support Office
400 Gigling Road
Seaside, CA 93955
1-800-538-9552
1-800-334-4162 (California only)
Monday through Friday, from 9 a.m. to 6:30 p.m. Eastern Time

For information on Social Security and to locate a Social Security office in your area:

Social Security Administration

1-800-772-1213
Monday through Friday, from 7 a.m. to 7 p.m.

For Medicare and Medigap information:

Medicare

Medicare Choices Helpline: 1-800-MEDICARE (1-800-633-4227); or, for the hearing or speech impaired, the TTY number is 1-877-486-2048.

Web site: *www.medicare.gov*

Medicare publications:

- *Medicare Supplemental Insurance Medigap Policies and Protections*, published in July 1999 by the U.S. Health Care Financing Administration (HCFA).
- *2000 Guide to Health Insurance for People with Medicare*, published by HCFA.

U.S. Health Care Financing Administration (HCFA) Web site: *www.hcfa.gov*

State Health Insurance Assistance Program (SHIP)

Contact the Medicare Choices Helpline at 1-800-MEDICARE (1-800-633-4227) for your local SHIP office information.

Note: The SHIP is also known as the State Health Insurance Program (SHIP) or the Senior Health Insurance Information Program (SHIIP) depending on your location.

Glossary

Assignment

In the Traditional Medicare plan, an assignment is a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full.

Authorized provider

An authorized provider is a doctor or other individual health care professional, or a hospital or supplier, who has been approved by a health plan to provide medical care and supplies. Typically, such a provider is licensed by the state, accredited by a national organization, and/or meets other standards of the medical community.

Capitation

Capitation is the fixed amount of money a managed care plan or health maintenance organization (HMO) pays a doctor or hospital for providing care to a patient, regardless of the actual cost.

Catastrophic cap

The maximum amount of certain covered charges you have to pay out of your pocket during the year. Setting a maximum amount protects you. Separate limits are usually applied on a per person and per family basis.

Coinsurance

Coinsurance is the amount a beneficiary pays for each service received. This amount typically is a percentage of the approved charge above and beyond the deductible. (See also **copay, copayment**.)

Coordination of benefits

For individuals with more than one insurance plan covering the same health care expenses, the "coordination of benefits" refers to how a particular beneficiary's health care costs are split among each insurer. One insurer—called the primary payer—pays the initial share of the cost as if it were the beneficiary's only plan. The others—the secondary payer, third payer and so on—then pay a percentage (or all) of the remaining cost. When the primary payer does not cover a particular service, but the secondary payer does, the secondary payer will pay up to its benefit limit as if it were the primary payer.

Copay, copayment

A copay or copayment is the amount you pay for each medical service, such as a doctor's visit. Note that a copayment is typically a *fixed amount*, while a coinsurance is a *percentage* of the total cost. For example, some plans charge a $10 copayment for a doctor's visit regardless of the actual full cost. (See also **coinsurance**.)

Deductible

A deductible is the amount you must pay for health care for each benefit period (typically a year) before your health plan begins to share the cost with you. A health plan may have separate deductibles for different types of services. Note also that deductibles can change every year or benefit period.

Disenroll
To disenroll from a health plan is to leave or end health care coverage with that plan.

Durable medical equipment
The term "durable medical equipment" (DME) refers to supplies a doctor orders for a patient's home use. DME, which must be reusable, includes walkers, wheelchairs and hospital beds.

Employer-sponsored health plan
An employer-sponsored health plan is group coverage for eligible employees and dependents for hospital, nursing, medical and surgical services.

End-Stage Renal Disease (ESRD)
ESRD is kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Medicare and may be eligible for Social Security payments if found to be disabled.

Enroll
To enroll in a health plan is to sign up or join.

Fee-for-service plan
A fee-for-service (FFS) plan is a traditional type of insurance that covers care received from any doctor or hospital, but typically includes an annual deductible as well as a coinsurance or copayment. "Fee-for-service" refers to the fact that doctors and other providers are paid for each office visit, test or other type of care given. Most FEHBP fee-for-service plans also provide access to preferred provider organizations (PPOs).

Fiscal intermediary
A fiscal intermediary is a private insurance company that has contracted with Medicare to process bills and claims for Medicare Part A services.

Health maintenance organization (HMO)
A health maintenance organization (HMO) is a plan that provides care through a network of doctors and hospitals in particular geographic or service areas. HMOs coordinate the health care services you receive. Your eligibility for a particular HMO is determined by where you live or, for some plans, where you work. Some FEHBP HMOs have agreements with providers in other service areas for non-emergency care if you travel or are away from home for lengthy periods.

Inpatient care
The term "inpatient care" is used to describe most types of health services that require an overnight hospital stay.

Managed care plans
Managed care plans provide health services to beneficiaries through a specified group of doctors, hospitals and other health care providers who receive a fixed monthly payment. Managed care plans include health maintenance organizations (HMOs), HMOs with point-of-service (POS) options, provider sponsored organizations (PSOs) and preferred provider organizations (PPOs).

Medical emergency
A medical emergency is defined as severe pain, an injury or sudden illness, or suddenly worsening illness that the patient believes may pose a serious threat to his or her health.

Medicare
Medicare is the federal health insurance program for people 65 years of age or over, as well as for certain younger people with disabilities or with

End-Stage Renal Disease (ESRD), a condition that can lead to permanent kidney failure and is treated by dialysis or a transplant.

Medicare-approved amount

The Medicare-approved amount is the upper limit deemed to be reasonable to charge for a service covered under Medicare Part B. Note that in some cases, the Medicare-approved amount may be less than the actual charge.

Medicare carrier

A Medicare carrier is a private insurance company that has contracted with Medicare to process beneficiary bills (claims) for Medicare Part B services.

Medicare+Choice

Medicare+Choice is Medicare's version of a health maintenance organization (HMO). These plans are not available in all states or localities.

Medicare managed care

See **Medicare+Choice**.

Medicare Part A

Medicare Part A is the federal hospital insurance that helps pay for Medicare beneficiaries' care in hospitals and skilled nursing facilities, as well as for home health care and hospice care. (See also **Medicare**.)

Medicare Part B

Medicare Part B is the federal medical insurance that helps pay for doctor visits, outpatient hospital care and some other medical services that Medicare Part A does not cover, such as physical and occupational therapy. (See also **Medicare**.)

Medicare SELECT

Medicare SELECT is a type of standardized Medigap insurance policy available in many states. Under Medicare SELECT, beneficiaries choose one of 10 standardized Medigap policies. However, since care is covered only when given by certain doctors and hospitals (except in an emergency), Medicare SELECT policies generally charge lower premiums than Medigap policies, which are less restrictive.

Medigap

Medigap is a type of supplemental insurance policy sold by private insurance companies to fill in the gaps not covered by traditional Medicare.

Open Season

A specified time frame each year when eligible individuals may enroll in the FEHBP Demonstration Project, and when beneficiaries may change plans. Eligible beneficiaries may enroll from November 13 through December 11, 2000, for health coverage beginning January 1, 2001. Eligible beneficiaries may enroll from November 12 through December 10, 2001, for coverage beginning January 1, 2002.

Original Medicare plan

See **Traditional Medicare**.

Out-of-pocket costs

Out-of-pocket costs are health care expenses patients pay because the costs are not covered by insurance. Such expenses include deductibles, coinsurance, copayments and other non-covered expenses.

Outpatient care

Outpatient care refers to most types of health services that do *not* require an overnight hospital stay.

Part A
See **Medicare Part A**.

Part B
See **Medicare Part B**.

Point of service (POS)
Point of service (POS) is a health plan that provides care through a network of doctors and hospitals in a particular geographic area. The plan typically coordinates the health care services you receive when you use plan-affiliated providers. However, the plan reimburses you for services received from providers outside the plan's network. Your out-of-pocket costs for these services are usually higher.

Preferred provider organization (PPO)
A preferred provider organization (PPO) is a fee-for-service plan that covers health care services received from plan-selected providers (medical professionals who have agreements with the plan). A PPO beneficiary pays less out of pocket for medical services from a plan-selected provider than from a non-PPO provider.

Premium
A premium is the fixed payment a policyholder owes to Medicare, an insurance company, or a health care plan.

Preventive care
Preventive care refers to medical services that help a patient maintain health or prevent illness. Such services can include routine physicals and flu shots, as well as some tests such as colorectal cancer screening and mammograms.

Primary care physician
In many Medicare managed care plans—as well as in private and FEHBP HMO plans—primary care physicians coordinate and provide most or all of a beneficiary's health care. For example, many plans require a beneficiary to obtain a referral from a primary care physician before seeing a specialist. When enrolling in an HMO-type plan, you may be asked to choose a primary care physician from a list of the plan's approved doctors.

Primary payer
The primary payer refers to the insurance company that pays first on a claim for medical care. (See also **coordination of benefits**.)

Provider-sponsored organization (PSO)
A provider-sponsored organization is a managed care organization established and owned by a group of doctors and hospitals to provide medical services. As a PSO beneficiary, you must use doctors and hospitals in that plan for your care to be covered.

Referral
A referral is your primary care physician's written approval for you to see a certain specialist or to receive certain services. Most HMOs and some Medicare managed care plans require referrals. Note that if you either see a different doctor than the one on the referral, or see a doctor without a referral and the service is not for an emergency or urgently needed care, you may be required to pay the entire bill.

Secondary payer
For individuals covered by more than one insurance plan, the secondary payer refers to the insurer who pays for some or all of the health care costs not

covered by the first insurer, or "primary payer." If the primary payer does not cover a particular service that the secondary payer does, the secondary payer will pay up to its benefit limit as if it were the primary payer. When an FEHBP fee-for-service plan is the secondary payer, it will pay the lesser of the following:

- its benefits in full, or
- an amount that when added to the benefits payable by the primary payer, equals 100 percent of covered charges.

Self-only coverage

Self-only is an FEHBP option that provides health care benefits only to the eligible beneficiary who enrolls in the plan.

Self-and-family coverage

An FEHBP option that provides health care benefits to Uniformed Services sponsors, their spouses and certain eligible dependents.

Service area

For plans that cover only services provided by a specified list of doctors and hospitals, service area refers to the region where those services are provided. Note the distinction between a service area and a demonstration area—a demonstration area, which is comprised of a specific list of ZIP codes, refers to the area in which a beneficiary must reside to be eligible for this particular demonstration project.

Sponsor

In the context of this demonstration project, a sponsor is defined as a member or former member of the Uniformed Services.

Survivor

In the context of this demonstration project, a survivor is defined as a dependent entitled to Military Health System benefits due to a Uniformed Services member's death either while on active duty or after retirement.

Traditional Medicare

Also called the Original Medicare plan, Traditional Medicare refers to the fee-for-service arrangement that covers Parts A and B services.

Uniformed Services

The term Uniformed Services is used to include the following groups:

- Members of the Armed Services (Army, Navy, Air Force, Marine Corps and the Coast Guard)
- Members of the Commissioned Corps of the Public Health Service
- Members of the Commissioned Corps of the National Oceanic and Atmospheric Administration

Election Form Instructions

The following instructions will help you complete the Federal Employees Health Benefits Program (FEHBP) Demonstration Project Health Benefits Election Form and Payment Election Form, both of which are required for enrollment. In addition to reading each question on the forms, these guidelines will help ensure that your responses are accurate and complete.

- For both forms, print legibly or type your entries.
- To enroll in the FEHBP Demonstration Project: On the Health Benefits Election Form, complete Parts A, B and G, as well as the "Remarks" box under Part H. See the step-by-step instructions below for completing each section. In addition, please complete the entire Payment Election Form.
- Your signature is required at the bottom of both forms. If your signature is not included, the form will be returned to you for signature.
- Please return both forms using the enclosed return envelope or in another envelope addressed to:

  Department of Defense
  TRICARE Management Activity
  c/o Iowa Foundation for Medical Care
  P.O. Box 71547
  Clive, IA 50325-0547

- Applications are accepted only by mail.
- To change your enrollment or to withdraw from the FEHBP Demonstration Project: Please call the Department of Defense (DoD) Customer Care Center toll free, 1-877-DOD-FEHB (1-877-363-3342).

Step-by-step instructions for completing the Health Benefits Election Form:

Part A

Item 1: Print or type your last name, first name and middle initial.

Item 2: Print or type your Social Security number.

Item 3: Print or type your date of birth, using numbers to show the month, day and complete year (for example, for April 12, 1935, put 04/12/1935, and for November 5, 1929, put 11/05/1929).

Item 4: Print or type your permanent home mailing address.

Item 5: Place an "X" in the appropriate box.

Item 6: Place an "X" in the box that signifies your current marital status. If you are separated, but not divorced, mark "married."

Item 7: Print the telephone number where you can be reached during normal business

hours. If you do not have a phone, please write "no phone."

Part B

Item 1: Print the plan name and the appropriate enrollment code. You can find the enrollment code on the front cover of the brochure for the plan that you are choosing. The enrollment code identifies not only the plan, but also whether you are selecting self-only coverage or self-and-family coverage.

If your enrollment is for self and family, complete all remaining items in Part B. If your enrollment is for self only, skip to Item 3 of Part B.

Item 2a: Print the last name, first name and middle initial of each eligible family member.

Item 2b: Print the U.S. Postal Service ZIP code of each eligible family member.

Item 2c: Print the date of birth of each eligible family member, using numbers to show the month, day and complete year.

Item 2d: Indicate "M" for male or "F" for female.

Item 2e: Provide the code that indicates the relationship of each eligible family member to you:

Code 1: Spouse

Code 2: Unmarried dependent child under age 22 (including an adopted child)

Code 3: Stepchild, foster child or recognized child born out of wedlock

Code 4: Unmarried disabled child age 22 or over who is incapable of self-support due to a physical or mental disability that began before age 22

Item 2f: Print the Social Security number of each eligible family member.

Item 3a: Place an "X" in the appropriate box for Item 3a. If you answer "Yes," enter the name of the policyholder in the space provided and complete Item 3b.

Item 3b: If you or any other eligible family member is now covered by Medicare, place an "X" in the Medicare box and indicate with an "X" Part A and/or Part B.

If you or any eligible family member is now covered by TRICARE (including CHAMPUS), place an "X" in that box.

If you or any covered family member have any other group insurance, place an "X" in the "Other" box and give the name of the insurance.

Skip Parts C, D, E and F of the Health Benefits Election Form.

Part G

Item 1: Read the "Warning" and the statements below, and then sign your name.

Signing your Health Benefits Election Form indicates that you understand and agree with the following statements:

- I understand that, as long as I am enrolled in the FEHBP Demonstration Project, I may not use any Military Health System services, including

pharmacy services and any inpatient or outpatient treatment/services provided at a military treatment facility, except in case of a medical emergency.

- I understand that I may not enroll in TRICARE Senior Prime, another demonstration program, as long as I am enrolled in the FEHBP Demonstration Project.
- To my knowledge, I am not eligible for enrollment in FEHBP through past civil service employment, either as a former employee or as a family member.
- I understand this demonstration project is currently scheduled to end December 31, 2002.

Item 2: Print or type the date you sign, using numbers to show the month, day and complete year (for example, 11/16/2000 for November 16, 2000).

Part H

In the "Remarks" section which is the last box at the bottom of the page, print the sponsor's full name and Social Security number. In the context of this demonstration project, a sponsor is defined as a member or former member of the Uniformed Services.

Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved: OMB No. 3206-0160

- *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*
- *Type or print firmly*
- *Sign and date in Part G*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. Your home mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Daytime telephone number *(include area code)* ( )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No ☐ Yes ☐ → Complete 3b — Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code →

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)*
2. Date of event that permits change *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*
2. Date received in employing office *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
3. Effective date of action *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. SF 2811 report number
5. Payroll office number
6. Payroll contact and telephone number *(including area code)* ( )
7. Personnel contact and telephone number *(including area code)* ( )
8. Signature of authorized agency official and telephone number *(including area code)* ( )

Remarks

Department Of Defense (DoD)
Federal Employees Health Benefits Program (FEHBP) Demonstration Project
Payment Election Form

A Enrollee

Enrollee Name_____ Enrollee Social Security #_____

Enrollee Date of Birth_____

B Method of Payment:

- o **Bill me directly.**
  Complete Section C
- o **Deduct payment allotment from my/my sponsor's retired military pay.**
  Complete Section D
- o **Deduct payment from my checking account or savings account using electronic funds transfer (EFT).**
  Complete Section E
- o **Automatically bill my VISA, MasterCard or American Express.**
  Complete Section F

Enrollee Signature_____Date_____

C I choose direct billing.

- Payment must be received by the due date to avoid disenrollment.
- You may pay by personal check, cashier's check or money order. Make checks payable to the DoD FEHBP. Be sure to sign the check or money order and include your account number.
- A fee will be charged for insufficient funds.

Enrollee Signature_____Date_____

D I choose to have the premium deducted from my/my sponsor's retired military pay.

- I understand processing of the allotment payments may take up to 60 days to activate. If my payment election is not successfully processed, I will be billed directly for the premiums due or I can authorize payment by credit card or electronic funds transfer.
- I understand that this authorization will remain in effect until the DoD FEHBP Demonstration Project receives written notification from me to terminate it.
- I understand that the DoD FEHBP will need a reasonable amount of time to process my termination request.
- Note: Only the sponsor may authorize a deduction. Survivors and former spouses may not use this option.

Sponsor Name_____ Sponsor Social Security #_____

Sponsor Signature_____ Date_____

E I choose to have the premium account balance deducted from my bank account through electronic funds transfer (EFT) automated transactions.

- If my payment option is not successfully processed, I will be billed directly for the premiums due or I can elect to pay by credit card.
- A fee will be charged for insufficient funds.
- I understand that this authorization will remain in effect until the DoD FEHBP receives written notification from me to terminate it.
- I understand that the DoD FEHBP will need a reasonable amount of time to process my termination request.

Account Holder's Name_____

Banking Information: ❑ Checking Account (Please attach a voided check)
❑ Savings Account (Please complete below)

Financial Institution Name_____

City_____ State_____ Zip_____

Account Number_____

ABA (Bank Routing) Number_____

Account Holder's Signature_____ Date_____

F I choose to have the premium automatically billed to my credit card.

- This authorization will remain in effect until the DoD FEHBP receives written notification from me to terminate it.
- If my payment option is not successfully processed, I will be billed directly for the premiums due.
- I understand that the DoD FEHBP will need a reasonable amount of time to process my termination request.

Check One:
❑ **VISA**
❑ **MasterCard**
❑ **American Express**

Credit Card Number: ❑❑❑❑ ❑❑❑❑ ❑❑❑❑ ❑❑❑❑

Expiration date: _____/_____
MM / YYYY

Print the name as it appears on the credit card: _____

Credit Card Holder's Signature_____ Date_____
The signature authorizes the FEHBP to charge the above account for the appropriate FEHBP premium due.

Notes

For more information:

Department of Defense
TRICARE Management Activity
c/o Iowa Foundation for Medical Care
P.O. Box 71547
Clive, IA 50325-0547

1-877-DOD-FEHB (1-877-363-3342)
www.tricare.osd.mil/fehbp

TRICARE

Department of Defense
TRICARE Management Activity
c/o Iowa Foundation for Medical Care
6000 Westown Parkway, Suite 350E
West Des Moines, IA 50266-7771

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